DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

W-0001-001

Printed: 12/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495141	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

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K 000	INITIAL COMMENTS Surveyor: 21761 Construction Type: II(000) Number of stories: One Story Building description: The facility is a one-story building of unprotected, noncombustible construction with concrete floors. Sprinkler Status: The building is fully sprinklered and protected by NFPA #13 systems supplied by municipal water. An unannounced standard recertification Life Safety Code survey was conducted 12/27/16 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. This plan of correction is the facility's credible allegation of compliance. K 293 **1.) Address the corrective action taken for the identified problem.** The exit signs were ordered on 12/29/16 to be delivered on 01/04/17 and to be installed on 01/06/17. **2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified upon facility rounds on 01/03/17. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** The Maintenance Director and or Maintenance Assistant have added checking the courtyard exit signs to their Maintenance rounds checklist. **4.) Indicate how facility will monitor its performance.** The Maintenance Director and or Maintenance Assistant will review the Maintenance rounds checklist, along with work order history with the safety committee monthly and any issues will be submitted to the QAPI committee at least quarterly for additional recommendations. **5.) Date of correction.** Compliance Date is 01/19/17	
K 293 SS=F	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies	K 293		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Hershel Sink Interim Administrator 01/06/17

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 293	Continued From page 1 with less than 30 occupants where the line of exit travel is obvious.) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide exit signs, evidenced as follows; Findings include: On 12/27/16, at approximately 11:42 A.M., it was observed there are no exit signs provided from the enclosed courtyard back into the building. The Maintenance Director witnessed this evidence by observation and interview.	K 293	K 300 **1.) Address the corrective action taken for the identified problem.** The Facility Maintenance Director and Maintenance Assistant completed rated door testing and inspection on 01/06/17. **2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified on rated door testing and inspection on 01/06/17. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** The Maintenance Director and or Maintenance Assistant will test and inspect rated doors monthly and document findings for compliance. **4.) Indicate how facility will monitor its performance.** The documented findings and inspection of the rated doors will be submitted and discussed in the safety committee monthly and any issues will be submitted to the QAPI committee at least quarterly for additional recommendations. **5.) Date of correction.** Compliance Date is 01/19/17	
K 300 SS=F	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to test rated doors, evidenced as follows; Findings include: On 12/27/16 upon records review, at approximately 11:42 A.M., it was observed that documentation could not be provided for rated	K 300		

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K 300	Continued From page 2 door testing and inspection. (Sections 7.2.1.15.2, 7.2.1.15.3, 7.2.1.15.4) The Maintenance Director witnessed this evidence by observation and interview.	K 300	K 711 **1.) Address the corrective action taken for the identified problem.** The written emergency procedures as of 01/05/17 do include the removal of wheeled equipment stored in corridors. The Facility written emergency procedure booklets/binders/manuals at the nurses stations have been updated and revised as of 01/05/17 to match the facility master procedures manual. **2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified upon review of procedures and manuals on 01/05/17. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** The Director of Clinical Education will re-in service and reeducate staff on emergency procedure booklets/binders/manuals content and location. The Maintenance Director and or Maintenance Assistant will review and update the emergency procedures, Facility emergency booklets/binders/manuals as necessary and required on a monthly basis. **4.) Indicate how facility will monitor its performance.** The Maintenance Director and or Maintenance Assistant will review changes and updates to the Facility written emergency procedures and booklets/binders/manuals with the safety committee monthly and any issues will be submitted to the QAPI committee at least quarterly for additional recommendations. **5.) Date of correction.** Compliance Date is 01/19/17	
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide complete emergency procedures, evidenced as follows; Findings include: 1. On 12/27/16 at approximately 12:20 P.M., it was observed during record review that the written emergency procedures do not include the removal of wheeled equipment stored in corridors. 2. On 12/27/16 at various times during the survey, it was observed during record review that the written emergency procedure booklets at the nurses' stations do not contain the latest revisions to match the facility's master	K 711		

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K 711	Continued From page 3 procedures manual. The Administrator witnessed this evidence by observation and interview.	K 711	**K 753** **1.) Address the corrective action taken for the identified problem.** The decorative holiday cardboard fireplace was removed from the main lobby on 12/27/16 by facility staff. **2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified during facility rounds and observation on 12/27/16. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** Current staff will be re-educated and re-in serviced on combustible holiday decorations by the Director of Clinical Education. The resident council will be re informed of regulation requirements. The Maintenance Director and or Maintenance Assistant will add combustible decorations to the Maintenance round checklists. **4.) Indicate how facility will monitor its performance.** The Maintenance Director and or Maintenance Assistant will review the Maintenance rounds checklist pertaining to combustible decorations at the safety committee meeting with those minutes forwarded to QAPI at least quarterly for trending and tracking as well as additional recommendations for compliance if required. **5.) Date of correction.** Compliance Date is 01/19/17	
K 753 SS=F	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. * Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to comply with the requirements for combustible decorations. Findings include: On 12/27/16, at approximately 12:35 P.M., it was observed that there is a large combustible cardboard fireplace in the main lobby. The Maintenance Director witnessed this evidence by observation and interview.	K 753		
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories	K 901		

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K 901	Continued From page 4 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide a formal and documented category risk assessment, evidenced as follows; Findings include: On 12/27/16 upon records review, at approximately 12:55 P.M., it was observed that no documentation could be provided for a formal and documented risk assessment. The Maintenance Director witnessed this evidence by observation and interview.	K 901	**K 901** **1.) Address the corrective action taken for the identified problem.** A category risk assessment was documented and completed on 01/04/17 by the Administrator and Nurse Unit Managers **2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified at this time 01/04/17. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** The Facility Administrator, Director of Nursing and or Nurse Unit Managers will complete a formal and documented category risk assessment monthly. **4.) Indicate how facility will monitor its performance.** The Facility Administrator, Director of Nursing and or Nurse Unit Managers will trend and report any issues from the monthly risk assessment to the QAPI committee for additional follow up. **5.) Date of correction.** Compliance Date is 01/19/17	
K 914 SS=F	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are	K 914		

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K 914	Continued From page 5 tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide periodic testing of electrical equipment, evidenced as follows; Findings include: On 12/27/16 at approximately 11:10 A.M., it was observed during review of facility documentation there are no records of inspection and testing for non-hospital grade electrical receptacles in patient care areas. The Maintenance Director witnessed this evidence by observation and interview.	K 914	**K 914** **1.) Address the corrective action taken for the identified problem.** The Maintenance Director and Maintenance Assistant completed inspection and testing of non-hospital grade receptacles in patient care areas on 01/04/17. **2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified at this time by the Maintenance Director and Maintenance Assistant. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** The Maintenance Director and/or Maintenance Assistant will conduct inspection and testing of non-hospital grade electrical receptacles on at least an annual basis and monitor on Maintenance rounds checklists. **4.) Indicate how facility will monitor its performance.** The Maintenance Director will document any trends and corrective action taken and report monthly to the QAPI committee for further recommendations **5.) Date of correction.** Compliance Date is 01/19/17	
K 915 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required,	K 915		

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K 915	Continued From page 6 are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide electrical systems documentation, evidenced as follows; Findings include: On 12/27/16, upon records review, at approximately 11:57 A.M., it was observed there is no category documentation provided for essential electrical systems. The Maintenance Director witnessed this evidence by observation and interview.	K 915	**K 915** **1.) Address the corrective action taken for the identified problem.** Category documentation for essential electrical systems was completed on 01/03/17. **2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified upon completion of category documentation for essential electrical systems on 01/03/17. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** Category documentation for essential electrical systems will be updated monthly by the Administrator and or Maintenance Director / Maintenance Assistant to ensure compliance **4.) Indicate how facility will monitor its performance.** The Administrator and or Maintenance Director will document any trends and corrective action taken and report monthly to the QAPI committee for further recommendations **5.) Date of correction.**	
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and	K 918	Compliance Date is 01/19/17	

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K 918	Continued From page 7 critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide emergency generator maintenance, evidenced as follows; Findings include: 1. On 12/27/16 at approximately 12:57 P.M., it was observed during record review that there are no records of the generator battery electrolyte levels. 2. On 12/27/16 at approximately 12:58 P.M., it was observed during record review that there are	K 918	**K 918** **1.) Address the corrective action taken for the identified problem.** Maintenance completed documentation of generator battery electrolyte levels on 01/04/17. Generator monthly testing was completed on 12/28/16. Documentation was located after survey. **2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** Documentation for generator battery electrolyte, generator testing will be updated and documented monthly by the Maintenance Director / Maintenance Assistant and forwarded to the Administrator for review and compliance **4.) Indicate how facility will monitor its performance.** The Administrator and or Maintenance Director will document any trends and corrective action taken and report to the QAPI committee quarterly for further recommendations **5.) Date of correction.** Compliance Date is 01/19/17	

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K 918	Continued From page 8 no records of generator monthly testing for several months. The Maintenance Director witnessed this evidence by observation and interview.	K 918	K 919 **1.) Address the corrective action taken for the identified problem.** The junction box was to be installed by the electrician on 01/06/17.	
K 919 SS=D	NFPA 101 Electrical Equipment - Other Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain electrical equipment, evidenced as follows; Findings include: On 12/27/16 at approximately 2:56 PM, it was observed there is an electrical wiring splice that is not protected by an approved junction box for the exhaust fan behind the clothes dryers. The Maintenance Director witnessed this evidence through observation and interview.	K 919	**2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified upon facility rounds on 01/06/17. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** The Maintenance Director and or Maintenance Assistant have added checking the laundry junction boxes to their Maintenance rounds checklist. **4.) Indicate how facility will monitor its performance.** The Maintenance Director and or Maintenance Assistant will review the Maintenance rounds checklist, along with work order history with the safety committee monthly and any issues will be submitted to the QAPI committee at least quarterly for additional recommendations. **5.) Date of correction.** Compliance Date is 01/19/17	
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled	K 920		

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K 920	Continued From page 9 by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to properly use electrical equipment, evidenced as follows; Findings include: 1. On 12/27/16 at approximately 12:40 P.M., it was observed by inspection that there is an unapproved multiple-outlet extension cord powering the Christmas tree in the entrance lobby. 2. On 12/27/16 at approximately 3:05 P.M., it was observed by inspection that there is an unapproved multiple-outlet adapter in use in the Activities Room of A-Wing. The Maintenance Director witnessed this evidence by observation and interview.	K 920	**K 920** **1.) Address the corrective action taken for the identified problem.** The multiple-outlet extension cords and adapter in the lobby and Activities Room were removed on 12/27/16. **2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified upon rounds on 01/04/17. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** The Maintenance Director and Maintenance Assistant will check and document weekly on their Maintenance rounds checklists that areas are checked for multiple extension cords and adapters. **4.) Indicate how facility will monitor its performance.** The Maintenance Director and or Maintenance Assistant will review the Maintenance rounds checklists monthly and submit findings to the safety committee monthly and any issues will be submitted to the QAPI committee at least quarterly. **5.) Date of correction.** Compliance Date is 01/19/17	
K 921	NFPA 101 Electrical Equipment - Testing and	K 921		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495141	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921 SS=F	Continued From page 10 Maintenanc Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide testing of electrical equipment, evidenced as follows; Findings include:	K 921	**K 921** **1.) Address the corrective action taken for the identified problem.** Portable Patient Care Related Electrical Equipment will be inspected and tested by Maintenance Director and Maintenance Assistant by 01/10/17 **2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** The Maintenance Director and Maintenance Assistant will test and inspect all portable patient care related electrical equipment weekly on their Maintenance rounds checklists. **4.) Indicate how facility will monitor its performance.** The Maintenance Director and or Maintenance Assistant will review the Maintenance rounds checklists related to portable patient care related electrical equipment monthly and submit findings to the safety committee monthly and any issues will be submitted to the QAPI committee at least quarterly. **5.) Date of correction.** Compliance Date is 01/19/17	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495141	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 11 On 12/27/16 at approximately 11:20 A.M., it was observed during review of facility documentation there are no records of inspection and testing for portable patient care related electrical equipment. The Maintenance Director witnessed this evidence by observation and interview.	K 921	**K 923** **1.) Address the corrective action taken for the identified problem.** Signage was ordered on 12/28/16 and installed on the doors on 01/03/17.	
K 923 SS=F	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923	**2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified upon rounds on 01/03/17. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** The Facility Maintenance Director and or Maintenance Assistant will document that the oxygen storage rooms have the proper signage that includes the required wording on their Maintenance rounds checklists. **4.) Indicate how facility will monitor its performance.** The Maintenance Rounds checklists will be reviewed and submitted to the Administrator weekly for tracking and trending and results reported to the Safety Committee monthly and QAPI committee at least quarterly for additional recommendations. **5.) Date of correction.** Compliance Date is 01/19/17	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495141	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 12 cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to properly mark medical gas storage, evidenced as follows; Findings include: On 12/27/16 at various times it was observed by inspection that the oxygen storage rooms signage throughout the facility did not include the wording ""CAUTION: OXIDIZING GAS(ES) STORED WITHIN. NO SMOKING", at a minimum. The Maintenance Director witnessed this evidence by observation and interview.	K 923		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

W-0001-002

Printed: 12/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495141	A. BUILDING 02 - PHARMACY DISPENSING AREA B. WING _____	12/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 21761 Construction Type: II(000) Number of stories: One Story Building description: The facility is a single room within the Main one-story building of unprotected, noncombustible construction with concrete floors. This room is the Pharmacy Storage room only, and does not contain sleeping areas. Sprinkler Status: The building is fully sprinklered and protected by NFPA #13 systems supplied by municipal water. An unannounced standard recertification Life Safety Code survey was conducted 12/27/16 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. This plan of correction is the facility's credible allegation of compliance.	
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of	K 918		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Interim Administrator 01/06/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495141	A. BUILDING 02 - PHARMACY DISPENSING AREA B. WING _____	12/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 1 supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide emergency generator maintenance, evidenced as follows; Findings include: 1. On 12/27/16 at approximately 12:57 P.M., it was observed during record review that there are no records of the generator battery electrolyte	K 918	**K 918** **1.) Address the corrective action taken for the identified problem.** Maintenance completed documentation of generator battery electrolyte levels on 01/04/17. Generator monthly testing was completed on 12/28/16. Documentation was located after survey. **2.) Address how facility will identify similar occurrences of the problem.** No similar occurrences were identified. **3.) Identify measures/systemic changes to ensure deficient practice will not recur.** Documentation for generator battery electrolyte, generator testing will be updated and documented monthly by the Maintenance Director / Maintenance Assistant and forwarded to the Administrator for review and compliance **4.) Indicate how facility will monitor its performance.** The Administrator and or Maintenance Director will document any trends and corrective action taken and report to the QAPI committee quarterly for further recommendations **5.) Date of correction.** Compliance Date is 01/19/17	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495141	A. BUILDING 02 - PHARMACY DISPENSING AREA B. WING _____	12/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 2 levels. 2. On 12/27/16 upon records review, at approximately 12:58 P.M., it was observed during record review that there are no records of generator monthly testing for several months. The Maintenance Director witnessed this evidence by observation and interview.	K 918		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICE

W-0001-001

2012 LIFE SAFETY CODE
Form Approved OMB Exempt

FIRE SAFETY SURVEY REPORT 2012 CODE – HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
49-5141 K1	49-51417 K2

PART I — Life Safety Code, New and Existing
PART II — Health Care Facilities Code, New and Existing
PART III — Recommendation for Waiver
PART IV – Crucial Data Extract
OPTIONAL — Chapter 4 – NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies – CMS-2786T

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
Alleghany Health & Rehab Main Bldg. Admin: Herschel Sedoris	A. BUILDING 01 02 B. WING C. FLOOR K3	1725 Main Street Clifton Forge, VA 24422	A. ☑ Fully Sprinklered (All required areas are sprinklered) B. ☐ Partially Sprinklered (Not all required areas are sprinklered) C. ☐ None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
☑ MEDICARE ☑ MEDICAID	12/27/16 K4	8/15/1975 K6	5. ☑ 2012 EXISTING 6. ☐ 2012 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ☐ HOSPITAL 2. ☑ SKILLED/NURSING FACILITY 4. ☐ ICF/IID UNDER HEALTH CARE 5. ☐ HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. ☑ ENTIRE FACILITY 2. ☐ DISTINCT PART OF (SPECIFY) _____

3. ☐ IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ☐ YES b. ☐ NO

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID
105	0	105	105	0

7. A. ☑ THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. ☐ COMPLIANCE WITH ALL PROVISIONS 2. ☑ ACCEPTANCE OF A PLAN OF CORRECTION 3. ☐ RECOMMENDED WAIVERS 4. ☐ FSES 5. ☐ PERFORMANCE BASED DESIGN

B. ☐ THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR (Signature)	TITLE	OFFICE	DATE
SURVEYOR ID K10: 21761	Fire Marshal	State Fire Marshal's Office	12/28/16
FIRE AUTHORITY OFFICIAL (Signature) Teresa H Robinson	TITLE Fire Marshal Supervisor	OFFICE SFMO	DATE 12/29/16

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

FIRE SAFETY SURVEY REPORT 2012 CODE – HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
49-5141 K1	49-51417 K2

PART I — Life Safety Code, New and Existing
PART II — Health Care Facilities Code, New and Existing
PART III — Recommendation for Waiver
PART IV – Crucial Data Extract
OPTIONAL — Chapter 4 – NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies – CMS-2786T

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
Alleghany Health & Rehab Pharmacy Room Admin: Herschel Sedoris	A. BUILDING 02 02 B. WING C. FLOOR K3	1725 Main Street Clifton Forge, VA 24422	A. ☑ Fully Sprinklered (All required areas are sprinklered) B. ☐ Partially Sprinklered (Not all required areas are sprinklered) C. ☐ None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
☑ MEDICARE ☑ MEDICAID	12/27/16 K4	4/2013 K6	5. ☑ 2012 EXISTING 6. ☐ 2012 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ☐ HOSPITAL 2. ☑ SKILLED/NURSING FACILITY 4. ☐ ICF/IID UNDER HEALTH CARE 5. ☐ HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW	3. ☐ IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
1. ☐ ENTIRE FACILITY 2. ☑ DISTINCT PART OF (SPECIFY) One room inside the Main bldg	a. ☐ YES b. ☐ NO

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID
0	0	0	0	0

7. A. ☑ THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. ☐ COMPLIANCE WITH ALL PROVISIONS 2. ☑ ACCEPTANCE OF A PLAN OF CORRECTION 3. ☐ RECOMMENDED WAIVERS 4. ☐ FSES 5. ☐ PERFORMANCE BASED DESIGN

B. ☐ THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR (Signature)	TITLE	OFFICE	DATE
SURVEYOR ID K10 21761	Fire Marshal	State Fire Marshal's Office	12/28/16
FIRE AUTHORITY OFFICIAL (Signature)	TITLE Fire Marshal Supervisor	OFFICE SFMO	DATE 12/29/16

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

PART IV - FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS 2786 FORMS)

W-0001-002

Provider Number	Facility Name	Survey Date
K1 49-5141	Alleghany Health & Rehab - Pharmacy Rm	*K4 12/27/16

K6 DATE OF PLAN APPROVAL: 4/2013

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS: 02

NUMBER OF THIS BUILDING: 02

[B]

A. BUILDING
B. WING
C. FLOOR
D. APARTMENT UNIT

LSC FORM INDICATOR

HEALTH CARE FORM		
12	2786R	2012 EXISTING
13	2786R	2012 NEW

AHCO FORM		
14	2786U	2012 EXISTING
15	2786U	2012 NEW

ICF/IID FORM		
16	2786V, W, X	2012 EXISTING
17	2786V, W, X	2012 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

SMALL (16 BEDS OR LESS)

K8 [ ]
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 [ ]
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 [ ]
7. PROMPT
8. SLOW
9. IMPRACTICAL

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)

K321: [ ] K351: [ ]

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

ENTER E – SCORE

K5: [ ] e.g. 2.5

*K9 FACILITY MEETS LSC BASED ON *(Check all that Apply)*

A1. [ ]	A2. [✓]	A3. [ ]	A4. [ ]	A5. [ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. [ ]

K0180

A. [✓]	B. [ ]	C. [ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

PART IV - FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS 2786 FORMS)

W-0001-001

Provider Number	Facility Name	Survey Date
K1 49-5141	Alleghany Health & Rehab	*K4 12/27/16

K6 DATE OF PLAN APPROVAL

8/15/1975

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 02

NUMBER OF THIS BUILDING 01

[A]
A. BUILDING
B. WING
C. FLOOR
D. APARTMENT UNIT

LSC FORM INDICATOR

HEALTH CARE FORM		
12	2786R	2012 EXISTING
13	2786R	2012 NEW

AHCO FORM		
14	2786U	2012 EXISTING
15	2786U	2012 NEW

ICF/IID FORM		
16	2786V, W, X	2012 EXISTING
17	2786V, W, X	2012 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

SMALL (16 BEDS OR LESS)

K8 [ ]
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 [ ]
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 [ ]
7. PROMPT
8. SLOW
9. IMPRACTICAL

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)

K321: [ ] K351: [ ]

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

ENTER E – SCORE

K5: [ ] e.g. 2.5

*K9 FACILITY MEETS LSC BASED ON *(Check all that Apply)*

A1. [ ]	A2. [✓]	A3. [ ]	A4. [ ]	A5. [ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. [ ]

K0180

A. [✓]	B. [ ]	C. [ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY